

# Our Understanding of the Request

- CAQH CORE presented to the NCVHS Subcommittee on Standards in its role as an author of operating rules.
  - The CAQH CORE written testimony, available on the NCVHS website, includes items such as :
    - An overview of the CORE Phases I, II and draft Phase III rules specific to Eligibility and Claims Status (Exhibit 10).
    - Four examples of how CORE operating rules work with standards:
      - Example #1: CORE Rules and Non-Mandated Aspects of the HIPAA Standards.
        - » Eligibility: Driving ROI by Providing Robust Information.
        - » Claims Status: Reducing Confusion by Providing Framework .
      - Example #2: CORE Rules and Non-HIPAA Healthcare Standards.
        - » Acknowledgements: Addressing a “Black Hole” in Administrative Data Exchange.
      - Example #3: Non-HIPAA, Industry-Agnostic Standards.
        - » Connectivity: Promoting Interoperability.
      - Example #4: Non-HIPAA, Non-SDO-Developed Implementation Guides .
        - » ID Cards: Recognizing the Need for Phases.
    - The testimony includes detailed, real-world examples demonstrating how operating rules and standards work together.

# Our Understanding of the Request (cont'd)

- CAQH CORE, as a candidate for authoring operating rules, has been asked to present examples of the CORE rules with emphasis on how they relate to standards.
- The examples address the following as they relate to the operating rules:
  - Role
  - Users
  - Benefit and ROI
  - Support of Standards

# CORE Rules Overview

Rules	Phase I	Phase II	Phase III (draft)
<b>Eligibility Data Content</b>	For 10 key services: <ul style="list-style-type: none"> <li>• Coverage information</li> <li>• Static financials (co-pay, co-insurance, base deductibles)</li> <li>• In/out of network variances</li> </ul>	For 40 more services provide: <ul style="list-style-type: none"> <li>• Phase I + YTD deductible.</li> </ul>	For 30+ more services provide: <ul style="list-style-type: none"> <li>• All financial information required in Phase I and II, plus annual out of pocket maximums.</li> </ul>
<b>Infrastructure</b>	<ul style="list-style-type: none"> <li>• Connectivity via internet</li> <li>• <i>Acknowledgements</i></li> <li>• Real-time and batch turnaround times</li> <li>• System availability</li> </ul>	<ul style="list-style-type: none"> <li>• Connectivity: Phase I + plug and play method (SOAP) and digital certificates</li> <li>• Patient identification</li> </ul>	<ul style="list-style-type: none"> <li>• Connectivity enhancements to speak to coordination with other industry efforts.</li> <li>• Establishes process that allows for tracking claims in the adjudication system (<i>Acknowledgements</i>)</li> </ul>
<b>Claims Status</b>	N/A	<ul style="list-style-type: none"> <li>• Real-time claims status using Phase I infrastructure rules</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain claim history for 24+ months from time claim enters adjudication system.</li> <li>• “Floor” of code combinations to bring uniformity/consistent in reporting status.</li> </ul>
<b>Claim Payment/ Advice Remittance</b>	N/A	N/A	<ul style="list-style-type: none"> <li>• Promotes increased availability and usage of transaction through application of CORE infrastructure rules</li> <li>• Sets timeline for dual paper-electronic delivery</li> </ul>
<b>Prior Authorization</b>	N/A	N/A	<ul style="list-style-type: none"> <li>• Promotes increased availability and usage of transaction through application of CORE infrastructure rules</li> </ul>
<b>Health ID Card</b>	N/A	N/A	<ul style="list-style-type: none"> <li>• Specifications for human-readable data elements, 2 of which are also machine-readable.</li> </ul>



# Example #1: Phase I and II Eligibility Data Content Rule Overview

(CORE Rules and Non-Mandated Aspects of the HIPAA Standards)

- **Patient Financials:** For the Eligibility transaction (270/271), neither v4010 nor v5010 require the use of a number of data fields that could reduce the cost of manual processes and reduce provider bad debt. These non-mandated data elements of transaction 270/271 are denoted “situational” data elements and include: in/out of network variances on benefit-specific coverage, co-pays, base deductibles, and YTD deductibles. The CORE rules require that health plans populate these situational elements with the appropriate data, thus ensuring that the provider has a more robust knowledge of the benefits available to the patient. In response to the CORE Operating Rules and resulting industry usage and comfort, v5010 did include some of the Phase I requirements for delivering benefit coverage, e.g., added yes/no benefit covered for seven services. In turn, the Phase I and II rules are removing these requirements to ensure non-duplication.
- **Service Type Coverage Detail:** Additionally, CORE is supporting the delivery of this financial data for over 50+ high-volume service type codes (STC) that are in the 270/271 but are not mandated for use in either the v4010 or v5010. These high-volume service type codes were included in the CORE rules due to key criteria such as reduction in manual processes, and complementing industry efforts underway for delivery of data electronically, e.g., laboratory or x-ray results. To meet their full value, the STC need to be uniformly defined. CORE developed draft definitions for STC where they were not available, but noted in the CORE rules that ASC X12 had a key role in the creation of these definitions. To address this Phase I finding, ASC X12 decided in 2009 to create a new committee – separate from ASC X12. Once this new committee has completed its work, the definitions will be included in the standard and the operating rules will follow the standard.

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# Example #2: Phase II Connectivity Overview

(CORE Rules and Non-HIPAA, Industry-Agnostic Standards)

**Promoting Interoperability.** Connectivity is required to achieve real-time data exchange, and the Internet is an essential tool that can be used to accomplish this goal. Given the CORE focus to date (eligibility, claims status, referrals, and remittance), as well as its guiding principle to align with Federal efforts, Phases I and II support standards that have established national and international recognition, such as those of:

- The Internet Engineering Task Force (IETF).
- The Organization for the Advancement of Structured Information Standards (OASIS).
- The World Wide Web Consortium (W3C).

The CORE rule inclusion of these standards (SOAP, WSDL, SSL, HTTP, etc.) was guided by key criteria – such as clinical-administrative alignment, real-time data delivery, support for HIPAA mandates. The end results were rules that include policies and support for the phased adoption of these standards, thus addressing the maturity of the administrative data exchange ecosystem.

CORE certification and testing in this area of connectivity has been critical as providers, health plans, and vendors all need to connect to each other, and support the application of these standards to healthcare administration.

# Examples: CORE Guiding Principles Specific to Connectivity

- Developed using consensus-based approach among industry stakeholders and is designed to:
  - Facilitate interoperability.
  - Improve utilization of electronic transactions.
  - Enhance efficiency and help lower the cost of information exchange in healthcare.
  - Support not only Eligibility transactions, but also any other administrative transactions.
- Builds upon existing standards.
- Creates a base and not a “ceiling”.
  - E.g., certified entities need to provide CORE-certified connectivity interface but may offer additional connectivity interfaces to support their business needs.
- Provides a “safe harbor”.
  - Rule is supported/offered by any CORE-certified entity.
- Connectivity Rules *do not*:
  - Require trading partners to remove existing connections that do not match the rule.
  - Require that all CORE-certified entities use the CORE rule for all new connections.

# Summary of Example #1 and #2

CORE Rule Requirement Phase I, II & III	Transaction(s) to Which Requirement Applies		Requirements included in current Federal regulations (including v5010 of HIPAA)?	Critical Decisions Made by CORE: Industry Roadmap	Key Benefits to Market
	Eligibility (X12 270/271)	Claims Status (X12 276/277)			
<b>Connectivity, Security and Authentication</b>	X	X	No	Setting stage for change in Phase I, and making significant improvement to common industry methods in Phase II. Methodical analysis and alignment with ONC clinical vision for connectivity, e.g. NHIN CONNECT /Direct, as well as other industry efforts such as HIMSS's IHE.	<p>Payload agnostic (can use method to send any data, e.g. clinical, administrative).</p> <p>Safe Harbor to directly connect to trading partners (plug and play goal).</p> <p>Supported by HITSP for administrative transport; incorporated into X12/WEDI real-time adjudication connectivity method; supported by NCPDP on condition of adjustments to further address pharmacy.</p>
<b>Patient Financials (Co-pay, deductible, YTD deductibles, in/out of network variances, out of pocket maximums) for over 50+ services (benefits)</b>	X		No; ACA legislates need	<p>Alignment on services like laboratory and x-ray.</p> <p>How best to support X12 work.</p> <p>Incremental additions in Phase I, II and draft III.</p> <p>Not addressing timely enrollment responsibility role of employers and health plan sponsors.</p>	<p>Delivery of financials impacting provider bad debt.</p> <p>Adds significant ROI to use of v4010 and v5010 for providers, patients and health plans.</p>
<b>Patient Coverage reporting that is Service Type (e.g., benefit) Specific</b>	X		None required in v4010, Only 10 of the 50+ CORE required services (benefits) required in v5010	Developing operating rules that required this prior to v5010 being mandated.	High volume services can be verified before or at the time of service.

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[CORE Phase I and II rules were written with v5010 in mind, while draft Phase III was written following release of v5010. The Phase I and II rules have been reviewed for v5010 compliance and adjustments have been identified. See Appendix D.

# Who is Using These Specific CORE Rules and Why?

- Users

- All Phase I certified entities are using the first level of both rules, including:
  - Providers, e.g., Mayo, Montefiore, US Dept of Veteran Affairs, Wake Forest,
  - Health Plans, e.g., AvMed, HealthNet, Humana
  - Vendors and Clearinghouses, e.g., CSC, GE, No More Clipboard, VisionShare
- All CORE Phase II certified entities, including:
  - Health plans, e.g. Aetna, Aultcare, BCBS Tennessee, Harvard Pilgrim, WellPoint.
  - Vendors and Clearinghouses, e.g., athenahealth, Availity, Emdeon, NaviNet, RelayHealth, Siemens HDX, The SSI Group.

- Benefits/ROI

- The results of the Phase I Measures of Success Study are included in the written testimony. They address activity for health plans and their vendor and provider affiliates that cover 33 million lives. The Study for Phase II has been launched.
- Overall benefits include a reduction in claims denials, increase in patient eligibility verification, a significant reduction in time needed to connect to trading partners, and a significant increase in the use of electronic transactions.
  - Several states that have formed multi-stakeholder committees identified these rules as meaningful to their challenges.

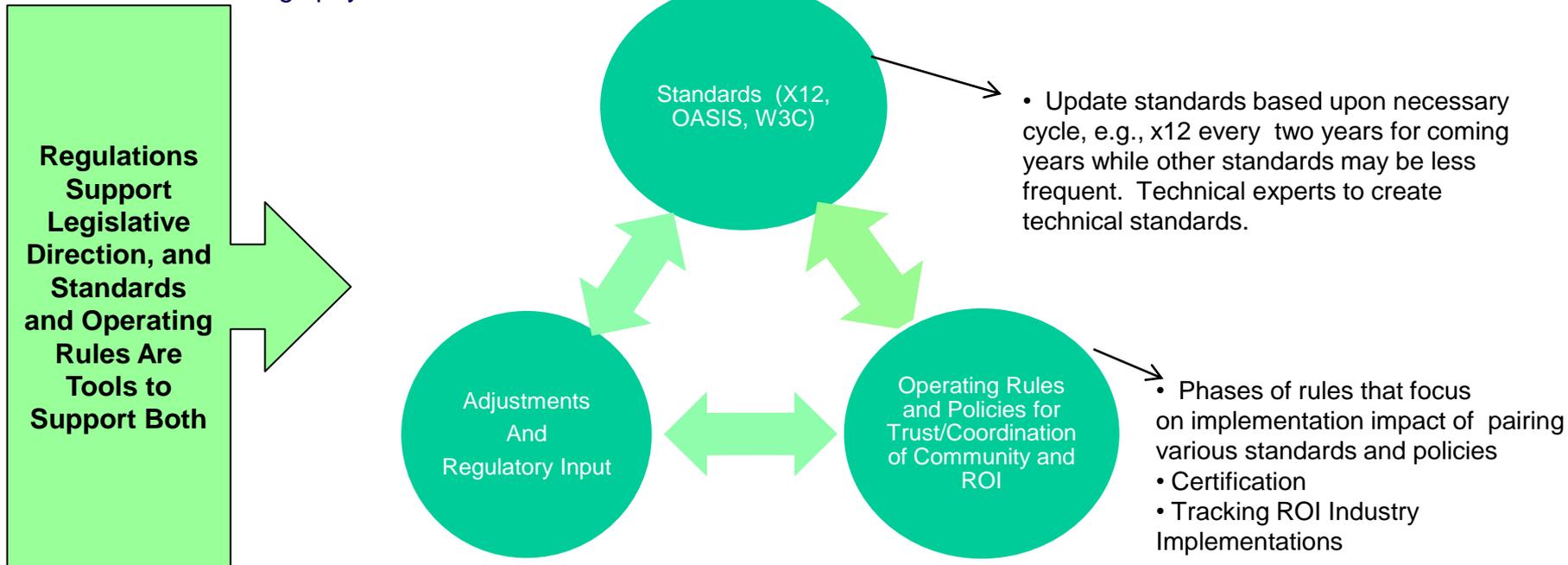
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# Operating Rules Build on Regulations, Support Various Standards and Establish Rules of Road

It is critical that there is an ongoing feedback loop between rules and standards. Examples:

- CORE to X12: Definitions needed for X12 270/271 service type codes for which financials need to be delivered, critical mass use of YTD deductibles, in/out of network.
- X12 to CORE: Updated acknowledgements for batch/real-time and edits, AAA code changes
- NCPDP - CORE: Agreed industry will benefit from adopting a common connectivity framework over which health information exchanges can occur; NCPDP adopted, but required some adjustments to CORE Connectivity, e.g., address use of MTOM for real time to support transport of non-printable characters in the message payload.



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# Points of Clarification

- Structure.
  - CAQH is an independent, non-profit organization, with an independent Board and Bylaws.
  - CORE is a CAQH sponsored initiative that is supported by CAQH staff, however, the CAQH Board does not have approval or veto rights over the CORE rules.
  - CORE participants make decisions through Subgroups, Work Groups and a steering committee, as well as a quorum-based voting process.

# Points of Clarification (cont'd)

- CORE Rules.
  - Operating rules are delivering *real-world business value (e.g., financials and plug and play)*.
  - The operating rules address standards that are, as well as those that are not, part of DSMO; and a wide range of policies that do not focus on the framework of the technical details.
  - The CORE operating rules are a base, not a ceiling.
  - The rules are all interdependent based on the business needs that they address, the relationships within the entities implementing and the relationships among the entities that exchange the data.
  - CORE includes data content due to the fact that business needs vary and change over time.
  - Standards and rules can have complementary but different cycles; standards can consider rules that have been developed based on market receptivity.
  - Address the administrative transactions related to the medical components of the industry; collaborate with other sectors, e.g., pharmacy, and lab, as the requirements are quite different.
  - Clinical and administrative data exchange can slowly collaborate, e.g. connectivity.

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